"Branching Out For Prevention"

Georgia Child Fatality Review Panel
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Mission

***T*o serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, (and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.) To promote the prevention of child deaths in Georgia that are preventable.**

This protocol manual was researched, organized and compiled by

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Georgia Child Fatality Review Panel

Special thanks to the State of Michigan and Texas Child Fatality Review Programs for sharing their review protocols, many of which were adapted for the State of Georgia

Revision(s) to this manual will be distributed to all committee members as laws of procedures change

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PREFACE

The child fatality review process was initiated in Georgia in 1990 as an amendment to an existing statute for child abuse protocol committees. This legislation provided that each county child abuse protocol committee establish a subcommittee to systematically and collaboratively review child deaths that were sudden, unexpected, and/or unexplained.

Child fatality review in Georgia has evolved over the years, adding more structure, definition, and members to the process. Members now form a stand-alone committee versus being a subcommittee, which has added emphasis to the importance of the function. Though the state Panel recommends changes of a systemic and political nature, it cannot bring the same vigor to the area of prevention that local committees can. Agencies working together at the local level offer the greatest potential for effective prevention and intervention strategies. Committees have the opportunity to convert tragedy into hope.

This manual is a step-by-step guide to assist you in the development, management, and maintenance of a child fatality review committee. Basic guidelines are offered with the understanding that unique differences within communities (e.g. resources, size, number of child deaths) will provide additional framework for the committees. Our staff is also available to assist you in any area of the child fatality review process. Please feel free to call on us.

Eva Pattillo
Executive Director

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I. Introduction

Child death is an unnatural and unacceptable phenomenon. Children are not supposed to die. Every death of a child is a tragedy, especially if that death could have been prevented. Each year in Georgia, hundreds of children die from unintentional injuries, intentional injuries, and SIDS. Local Child Fatality Review Committees report that most of these reviewed child deaths are definitely or possibly preventable. Georgia has established a Child Fatality Review system to better understand how and why our children die and to take action to prevent similar child deaths in the future.

Georgia's future is contingent upon the survival of its children. To ensure survival, we must protect and promote the safety and well being of all children. Child Fatality Review Committees have significant potential to improve service delivery and linkage among systems as Georgia endeavors to prevent deaths of children. We are committed to building a broad review process that addresses all preventable child deaths. By adopting this public health approach, a better understanding and greater awareness of preventable child deaths can be realized on the local and state level.

No child should die unnecessarily in Georgia. From our reviews we should identify what places children at risk of preventable deaths and take the steps necessary to avoid needless tragedies in the future.

This protocol manual was researched and developed to create a standardized procedure for local Child Fatality Review Committees to assure all child deaths that meet established criteria are reviewed.

II. Background on Child Fatality Review Committees

In 1989, reporter Jane Hansen published a series of seven articles in the *Atlanta Journal and Constitution.* The series, entitled "Suffer the Children," detailed 51 deaths among children who were ostensibly under the protection of Georgia's child welfare system. Hansen reported an alarming lack of investigation into the deaths of these children that often led to labeling the causes of deaths as "accidental" or "natural", when they in fact were a result of child abuse and/or neglect.

Public outcry in response to Hansen's series prompted former Governor Joe Frank Harris to commission a task force to study the issue of unexpected deaths of children in Georgia. Because of a lack of consistency in investigative methods used by many state agencies, the Governor and others feared that child deaths attributed to Sudden Infant Death Syndrome or presumed to be accidental were actually homicides. The task force issued a report recommending, among other things, a uniform death investigation process throughout the state. The recommended process would include deaths from all unexplained and unexpected causes, not just those alleged from child abuse and neglect. The task force concluded that Georgia must develop a system to accurately identify and record the cause and manner of every child death that was unexpected or unexplained.

In 1990, the Georgia General Assembly mandated that every county take a proactive role in investigating and preventing deaths among children by establishing child fatality review committees. The Georgia Child Fatality Review Panel was created to provide direction, oversight, and training for each of the159 county Child Fatality Review Committees.

A. The Need for Child Fatality Review Committees

Information regarding the causes of death among Georgia's children and risk factors present in the lives of these children who died unexpectedly was initially limited. National studies, along with the reviews conducted by child fatality review committees, show information recorded on death certificates is often inaccurate or incomplete. This information, even when accurate, does not tell the surrounding circumstances leading to the death of a child.

Often preventative measures to save a child, or risk factors leading to the death of a child were unknown. In some circumstances, particularly in cases

of suspected child abuse or neglect, investigators were unable to determine if foul play contributed to the child's death.

Georgia's system for identifying and responding to child deaths was limited in the following ways:

- Georgia did not have a standardized procedure for the in-depth review of child deaths.
- Georgia did not have a consistent comprehensive system to collect information on the involvement of state and local agencies with children and their families, either before or after a child's death.
- Except for highly sensational cases, many child deaths went unnoticed in a community and consequently only were known to those individuals or agencies that had direct involvement with the deceased child.
- A great deal of misinformation, confusion, and disagreement regarding SIDS existed among coroners, law enforcement, health care providers, families, and the general public.
- Responsibility of local agencies for the investigation, delivery of services, and implementation of preventive actions were often unclear.

B. Legislation

Title 19, Chapter 15, Section 3, Official Code of Georgia Annotated, states that each county shall establish a local multidisciplinary, multi-agency Child Fatality Review Committee. The chief superior court judge of the circuit in which the county is located shall establish a child fatality review committee composed of, but not limited to, the following mandated members:

- Coroner or county Medical Examiner
- District Attorney
- Department of Family and Children's Services
- Juvenile Court
- Public Health
- Mental Health
- Law Enforcement

Child Fatality Review Committees in Georgia are charged with reviewing child deaths when those deaths are suspicious, unexpected, or unexplained. As part of the review process, particular emphasis has been placed on determining whether deaths were preventable, and if preventable, what actions should be taken to prevent similar deaths in the future. For your convenience, a copy of the relevant legislation is provided in Section XVI.

III. Goal and Purpose of Child Fatality Review Committees

A. CHILD FATALITY REVIEW COMMITTEE GOAL

GOAL:
To ultimately prevent child fatalities that are preventable through the establishment of an effective review and standardized data collection system designed to:

- improve response to child fatalities
- improve understanding of how and why children die from intentional and unintentional injuries
- influence legislation, policies, and programs that effect the health, safety, and protection of children

B. PURPOSE OF THE REVIEW PROCESS

The purpose of local Child Fatality Review (CFR) Committees is to provide a confidential forum to determine the cause and circumstances around child deaths. CFR Committees strive to enhance the criminal investigation and prosecutorial process of child abuse and neglect homicides. The work of CFR Committees is:

1. **To accurately identify and uniformly report the cause and manner of every child death.**

   If the accuracy of child death determinations is to be improved, there must be a coordinated approach to the investigation and documentation of the death from the various agencies involved. Sharing of information is essential. Prior to the completion of the death certificate, a thorough death scene investigation, a background check for criminal history, and a search for prior reports of child abuse must be conducted by law enforcement and child protective services. Many deaths will require a review of the child's medical history. Committees provide a forum for ensuring that relevant information is available and shared which facilitates a better understanding of all the factors contributing to a child's death. This information assists in making a more accurate determination of how and why a child died. When Child Fatality Review Committees identify a lack of sufficient information to accurately determine how a child has died, the systematic collection of more information is agreed upon.

2. **To identify circumstances surrounding deaths that could prevent future deaths and initiate preventive efforts**.

   Local committees should use the data they collect to identify and recommend actions needed to reduce the number of preventable child deaths. Each CFR Committee should use their local data to base their recommendations for local preventative efforts, for assessing limited resources, and for promoting awareness and education on the management and prevention of child deaths in the community. The Office of Child Fatality Review is available for assistance in these efforts.

3. **To promote collaboration and coordination among the participating agencies.**

   Interagency communication is crucial in the review of child deaths. Communication between agencies must be maintained on a formal and informal basis. Feedback is useful in assessing intervention on a case-by-case basis and can be used to discuss successes and problems in coordination among agencies and professionals. It can also identify gaps in services and barriers to effective investigations. By agreeing on common goals, developing a clear understanding of professional roles and responsibilities, maintaining open communication, developing procedures for intervention and collaboration, and instituting procedures for feedback, committee members strengthen their working relationships with other agencies. Information regarding agency procedures, relevant programs and child death training needs are exchanged regularly at committee meetings. The outcome is a better use of limited resources and an enhanced ability to fill gaps in services in the area covered by the committee.

4. **To improve agency responses to child death investigations and delivery of services**

   Committee reviews can help identify problems regarding the coordination of investigations or the investigative responsibilities of different agencies. Reviews can identify ways a community can better conduct and coordinate investigations and can help to improve investigative resources.

   CFR Committees can enhance criminal investigations and improve the response of the criminal justice system to child homicides. A number of committees have identified child abuse deaths that initially appeared to be accidental or natural.

In addition, a number of counties report that they are much better informed on the very real occurrence of Sudden Infant Death Syndrome (SIDS) as it is distinguished from accidental or intentional suffocation.

Reviews can improve the delivery of services to families and others in a community following a child death. Bereavement services for families, stress debriefing services for first responders, counseling services in schools following traumatic deaths, and the protection of siblings in child abuse homicides are some of the services that should be offered.

5. **To promote the design and implementation of cooperative standardized protocols for the investigation of certain categories of child death.**

Child death investigations vary greatly across the state, depending on resources available to counties and levels of coordination among agencies. Reviews can assist agencies in developing standardized protocols to investigate and deliver services. An example is The Centers for Disease Control Guidelines for Death Scene Investigation of Sudden, Unexplained Infant Deaths that have been developed and endorsed by major state agencies. CFR Committees can help to ensure utilization of these protocols. Standardized protocols within and among counties can clearly define roles and standardized procedures, resulting in more accurate reporting of child deaths statewide. Suggested areas for development of local protocols are:

- Working with first responders to better protect child death scenes.
- Implementing a multi-agency response team to investigate child death scenes.
- Developing hospital emergency room protocols to identify child abuse, and report all child deaths.

6. **To propose needed changes in legislation, policies, and procedures.**

The Child Fatality Review Committee's ultimate purpose is to prevent child deaths. Every review of every child death should conclude with a discussion of how the committee can prevent another similar death in the community. Committees can focus their discussion on short and long-term interventions relating to policy, programs and practice. Committees are not expected to design and implement recommendations; reviews are intended to catalyze community action. Committees should identify the best way to translate prevention recommendations into actions. Individual agencies or committee

members can assume responsibility and work with existing prevention coalitions or establish new ones.

The reviews have led to many initiatives, including short-term, easy to fix problems and long-term, extensive planning efforts.

The Panel will develop state level recommendations for policy and practice in child health, safety and protection based on the collective experiences and recommendations of the county review committees.

IV. Establishing a Child Fatality Review Committee

To establish a multi-agency, multidisciplinary Child Fatality Review (CFR) Committee in your community it is essential that all professionals composing committee membership be willing to commit the time and effort required to form a committee.

The District Attorney (or his/ her designee) shall serve as the chairperson to preside over all child fatality review committee meetings. Vacancies on the committee are filled by appropriate agencies or the chief superior court judge.

Failure of a designated office to participate fully in the work of the committee is punishable as contempt of court by the chief superior court judge. The Panel, however, recommends that the committee exhaust all informal means of persuasion before requesting the chief superior court judge to issue a contempt order. The Panel staff is available to assist committees in these matters.

A County or a Circuit-wide Child Fatality Review Committee:

Effective 2001, county CFR Committees are to recommend whether to have a review committee for their county alone or to establish a review committee with the counties within the judicial circuit. The advantage of a circuit-wide CFR Committee is to maximize the resources and expertise of counties that individually experience few child fatalities in any calendar year. The composition of a circuit-wide CFR Committee should reflect all agencies represented on local committees. The Panel recommends that counties choosing this option negotiate membership among themselves in consultation with the chief superior court judge of the circuit. The Panel staff is available to assist committees in this process.

V. Committee Membership

Membership of the CFR Committee is extremely diverse, representing nearly all disciplines having a concern with the welfare of the child and family. The most important aspect of committee membership is that members be multidisciplinary and multi-agency. The comprehensive review of fatalities must include input from all related agencies.

Mandated Members: (by statute or policy)

- Coroner or county Medical Examiner
- District Attorney or designee
- Department of Family and Children's Services (DFCS) Representative
- Juvenile Court Representative
- Public Health Representative
- Mental Health Representative
- Law Enforcement Representative
- Prevention Advocate

Ad hoc committee members may be included, as the need exists. Other individuals that may be included for appointment to the committees are: citizens of advocacy groups that focus on child abuse awareness and prevention, faith-based organizations, hospitals, school systems, and civic organizations representing minority communities.

Each committee member has a specific role in the review process. These roles stress coordination and communication among agencies as well as the perspective of the individual agency. The role of committee members can be flexible to meet the needs of a particular community. The individual abilities of members should be used to form the most effective committee possible. Failure to comply with membership responsibilities shall be punishable by contempt of court (Code Section 19-15-3[d]). Each member should:

- Contribute information from his or her records
- Serve as a liaison to respective professional counterparts
- Provide definitions of professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession
- Assist in making referrals for services or providing direct aid to surviving family members

All committee members must have a clear understanding of their own and other professionals' and agencies' roles and responsibilities in response to child fatalities. Additionally, members need to be aware of and respect the expertise and resources

offered by each profession and agency. The integration of these roles is the key to a community having a well-coordinated child fatality review system.

VI. The Role of Committee Members

Chairperson Roles and Responsibilities:

The District Attorney (or his/her designee) shall serve as the chairperson to preside over all child fatality review meetings. **The chairperson is not a separate member**; rather he or she is already a committee member and is designated by the committee to oversee data collection and to help organize/facilitate meetings.

When the chairperson of the CFR Committee receives a report from the coroner or the medical examiner regarding the death of a child, that chairperson shall review the report and findings as follows:

If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with the decision, he or she should sign the form designated by the Panel (Form 1) stating the death does not meet criteria for review. The chairperson shall forward the form and findings to the Panel within **seven days** of receipt. If the chairperson believes that the death of a child meets the criteria for review, he or she should convene the committee within **30 days** of receipt of the report. Other responsibilities are as follows:

- Accept report and notification from the medical examiner or coroner about the death of a child
- Make a determination from the available resources, and according to established criteria, of the cases to be reviewed by the committee
- Distribute the list of cases to be reviewed to the committee members
- Arrange to have the necessary information from investigative reports, medical records, autopsy reports or other items made available to members of the committee
- Schedule and notify the committee members of upcoming review meetings
- Chair the committee meetings
- Oversee overall adherence to the child fatality review process

- Arrange to have the necessary information from investigative reports, medical records, autopsy reports or other items made available to members of the committee
- Schedule and notify the committee members of upcoming review meetings
- Chair the committee meetings
- Oversee overall adherence to the child fatality review process
- Ensure that all reporting and data collection requirements are met including reports being forwarded to the District Attorney and the Panel
- Serve as liaison with each local agency, with other Child Fatality Review Committees, and with the Georgia Child Fatality Review Panel

Medical Examiner/Coroner Role and Responsibilities:

If the death of a child occurs within the county of residence, the local medical examiner or coroner will notify the chairperson of the local CFR Committee within **48 hours** of the child's death. If the death occurs outside the child's county of residence, the attending coroner or medical examiner will notify the chairperson and coroner or medical examiner in that child's county of residence within **48 hours** of the child's death. (O.C.G.A. 19-15-3)

The medical examiner or coroner shall review the findings regarding the cause and manner of death for each child death report that he or she receives in the following manner:

> If cause of death meets the criteria for review (pursuant Code Section 19-15-3[e]), the medical examiner or coroner shall complete and sign the form designated by the Panel (Form1) stating the death met the criteria for review. He or she shall forward the form findings, within **seven days** of the child's death, to the chairperson of the CFR Committee in the county or circuit of the child's residence. If cause of death does not meet the criteria for review the medical examiner or coroner shall complete and sign the form stating that the death did not meet the criteria for review and forward the form findings, within **seven days** of the child's death, to the chairperson of the CFR Committee in the county or circuit of the child's residence. Other responsibilities are as follows:
>
> - Provide pertinent health and medical information regarding a child whose death is being reviewed by the CFR Committee
> - Provide forensic information and analysis, including autopsy reports
> - Participate in identifying risk factors to child safety and strategies to address these

- If a child is not a resident of the county in which he or she died, the coroner or medical examiner shall forward all information and all reports to coroner or medical examiner and CFR Committee chairperson in the county or circuit of the child's residence within the specified time frames
- Act as liaison with counterparts across the state

District Attorney Role and Responsibilities:

- Act as chairperson or designate a chairperson for the CFR committee.
- Explain criteria for pursuing a criminal or civil case, and keep committee informed about any actions taken in connection with a child's death
- Identify previous criminal or civil filings involving the child, family members or others involved with a child's death
- Provide victim assistance
- Participate in identifying risk factors to child safety and strategies to address these
- Act as liaison with counterparts across the state

Department of Family and Children Services (DFCS) Roles and Responsibilities:

- Conduct case investigations and intervention as appropriate
- Identify previous contacts of the child and family with DFCS
- Provide services to surviving siblings and family members at risk
- Develop intervention and public awareness programs to protect children at risk
- Make placement decisions
- Acts as liaison with counterparts in Georgia and other states

Juvenile Court Roles and Responsibilities:

- Identify previous contacts of the child and family with the Juvenile Court and/or Department of Juvenile Justice
- Make placement decisions; order follow-up services and case management to surviving siblings referred by DFCS
- Participate in identifying risk factors to child safety and strategies to address these risk factors
- Act as liaison with counterparts across the state

Public Health Roles and Responsibilities:

- Identify previous contacts of the child and family with the health department.

- Provide epidemiological, morbidity and mortality data to assist in the evaluation
- Promote intervention and public awareness programs to protect families and children at risk
- Act as liaison to counterparts across the state

Mental Health Roles and Responsibilities:

- Provide information about any services sought or received by the child or family prior to the death
- Assist in the discovery and review of the child's mental health or substance abuse records from public and private providers
- Provide follow-up services to surviving family members
- Promote intervention and public awareness programs to protect families and children at risk
- Act as liaison with counterparts across the state

Law Enforcement Roles and Responsibilities:

The responsibilities of the officer at the scene include: interviewing, documenting, and taking photographs at the death scene. The officer also assists the coroner or medical examiner in determining the cause, manner and mode of death. Other responsibilities are as follows:

- Conduct primary case management of investigation when there is possible criminal action
- Provide information on criminal histories of the child and/or family and suspects in child fatality cases
- Provide investigation or criminal records of child and family (i.e. reports, scene photographs, etc.)
- Participate in identifying risk factors to child safety and strategies to address these
- Act as liaison with counterparts across the state

Prevention Advocate Roles and Responsibilites:

- Facilitate discussion on prevention for each and every child fatality your committee reviews.
- Track data on child fatalities for your county in order to help the committee define/ redefine prevention strategies.
- Educate committee members on proven prevention tactics.
- Compile information and use this information to assist the committee with making changes in policy and legislation.
- Serve as a liaison/ link between the committee and various community resources.